

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011773

STATE FILE NUMBER

Registrar's No. 868

APR 6 1959

Registration District No. 317

Primary Registration District No. 590

590

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-57

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St Johns</u>		c. CITY OR TOWN <u>St Johns 4211</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boulevard Manor</u>		d. STREET ADDRESS (If outside, give location) <u>3300 Emmerich</u>	
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>Vogel</u> Last <u>McCoy</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Benjamin Vogel</u>		13b. MOTHER'S MAIDEN NAME <u>Bertha Vogel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Walter Ladner, 530 N. Union</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>Lung Congestion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4222</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>Mar 1-58</u> to <u>Mar 30-59</u> and last saw her alive on <u>Mar 30-59</u> Death occurred at <u>P. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. C. Schumacher M.D.</u> (Degree or title)		22b. ADDRESS <u>8863 Audover</u>	22c. DATE SIGNED <u>3-31-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/1/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Int Sinai</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS CO. MO</u>
24. FUNERAL DIRECTOR <u>Wayer 4356 Indale</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>3-31-59</u>	REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No. 3749
P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.